Coordination of Benefits Indicator Form

WellSense HEALTH PLAN

Member information

Date	Name
Head of household (if different from above)	
Address	
City, State, Zip	
Phone	DOB
SSN	Member ID

Medicare information

Name (Last, first, middle)		Claim number
Part A	Start date:	End date:
Part B	Start date:	End date:

Commercial health insurance information

☐ New policy ☐ Changed policy ☐ Terminated/closed policy
☐ Additional policy ☐ Policy ended due to leaving job

Policy holder's name (first, last, middle initial)

Date of birth	SSN
Policy number	Group number
Policy start date	Policy end date

Insurance company

Name

Address

Phone

Family members covered

Name	SSN
Name	SSN
Name	SSN
Name	SSN

Access to employer-sponsored health insurance

If not currently insured, does any family member's employer offer health insurance?

☐ Yes ☐ No

Employer/union name

Employer/union address

Employer/union telephone

Mail or fax this form to:
WellSense Health Plan
Provider Audit and Other Party Liability
529 Main Street Suite 500
Charlestown, MA 02129